



**Pediatric Intake Form
Jennifer French, L.Ac.**

Patient Name: _____

Mother Name: _____ Father Name: _____

Date of birth: _____ Time of birth: _____

Location of birth: _____

Address: _____

Primary phone #: _____ Second phone #: _____

Referred by _____

Primary care physician: _____

Physician Phone Number: _____

Last appointment date: _____ Reason: _____

Missed Appointment Policy: Please change your appointment within 24 hours. Failure to do so will result in a \$55.00 fee. Please check to acknowledge policy ____

Confidentiality: Your patient records and information will be kept confidential and shared only when necessary to provide care and services, or by your authorization, or when permitted by law. Please check to acknowledge policy ____

Last illness: _____ Date: _____

Current Medications: _____

Current Supplements: _____

Prior Trauma / Surgeries: _____

What is the main complaint? _____

What are the symptoms that are affecting the child: _____

PATIENTS NAME _____ DOB _____

Vaccinations

MMR____ Hep B____ Chickenpox____ Hib____ DtaP____ Influenza____ Pneumococcal____
Polio____ HPV _____ Flu Shot _____

BIRTH: Home____ birthing center____ Hospital____

ANY COMPLICATIONS DURING BIRTH: _____

ANY STRESS TO MOTHER DURING PREGNANCY:

SLEEP HABITS: (DIFFICULTY FALLING ASLEEP, WAKING UP IN NIGHT, BEDWETTING)

Allergies: _____

Is child still breast-feeding? _____ Formula? _____ Which brand: _____

Child Menstrual/Reproductive History: _____

Emotional Health Concerns (if any): _____

Is the child affected by: wind cold heat Explain _____

FAMILY

Significant Family Health Issues: _____

Mother

Date of birth: _____ Birth Time: _____ Birth Place: _____

Menstrual/Reproductive History: _____

Significant Health Events:

Date:

Father

Date of birth: _____ Birth Time: _____ Birth Place: _____

Significant Health Events:

Date:

What would you like the focus of treatment be for your child?

Please describe living arrangements at home (are both parents living at home, siblings, sleeping arrangements).

DIET & ENERGY

Does the child have a good appetite? _____

Is the child thirsty? _____

Is the child picky over food? _____

What is a usual breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Child Energy Level: _____

Does child have enough energy? _____

Does child have too much energy? _____

Does the child have regular bowel movements? _____

Color of Stool: _____

Please describe:

___ Foul Smelling ___ Flatulence ___ Bloating ___ Diarrhea ___ Loose Stools

___ Constipation ___ Undigested food ___ Explosive ___ Blood in stool

___ Other _____

Does the child have history of bladder infections? _____

___ Frequent Urination